

		FOR OFF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0043547

Facility Name: Firwood Health Care Center

Address: 520 Fabyan Parkway Batavia 60510
Number City Zip Code

County: Kane

Telephone Number: (630) 879-5266 Fax # (630) 879-5214

IDPA ID Number: 830320180014

Date of Initial License for Current Owners: 2/7/1998

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust
IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☐ "Sub-S" Corp.
☒ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: William H. Keys Telephone Number: (317) 566-1586

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	William H. Keys	
	(Title)	Chief Financial Officer	
Paid Preparer	(Signed)		(Date)
	(Print Name and Title)	Chris Murphy, CPA Partner	
	(Firm Name & Address)	BKD, LLP 6120 S. Yale, Suite 1400	
	(Telephone)	(918) 584-2900	Fax # (918) 584-2931
	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001		
	Phone # (217) 782-1630		

Facility Name & ID Number Firwood Health Care Center

0043547 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	63	Skilled (SNF)	63	23,058	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	63	TOTALS	63	23,058	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	11,138	2,646	0	13,784	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,138	2,646		13,784	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.78%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 2/7/1998

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 2/7/1998 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number of beds certified _____ and days of care provided 0

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRAUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **Firwood Health Care Center** # **0043547** Report Period Beginning: **1/1/2004** Ending: **12/31/2004**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	109,588	6,241	3,600	119,429		119,429		119,429			1
2	Food Purchase		56,808		56,808		56,808	(610)	56,198			2
3	Housekeeping	57,466	7,375		64,841		64,841		64,841			3
4	Laundry	11,015	4,716	35	15,766		15,766	(155)	15,611			4
5	Heat and Other Utilities			49,984	49,984		49,984	(2,243)	47,741			5
6	Maintenance	15,518	7,693	15,613	38,824		38,824	972	39,796			6
7	Other (specify):* Waste Removal			2,724	2,724		2,724		2,724			7
8	TOTAL General Services	193,587	82,833	71,956	348,376		348,376	(2,036)	346,340			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	526,405	28,698	97,329	652,432		652,432	3	652,435			10
10a	Therapy											10a
11	Activities	25,611	572	3,062	29,245		29,245		29,245			11
12	Social Services	17,551		3,503	21,054		21,054		21,054			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Non allow cost											15
16	TOTAL Health Care and Programs	569,567	29,270	111,094	709,931		709,931	3	709,934			16
	C. General Administration											
17	Administrative	5,088		82,281	87,369		87,369		87,369			17
18	Directors Fees											18
19	Professional Services			20,014	20,014		20,014	11,200	31,214			19
20	Dues, Fees, Subscriptions & Promotions			18,107	18,107		18,107	(1,606)	16,501			20
21	Clerical & General Office Expenses	33,145	8,659	13,713	55,517		55,517	133,028	188,545			21
22	Employee Benefits & Payroll Taxes			146,521	146,521		146,521		146,521			22
23	Inservice Training & Education											23
24	Travel and Seminar			24,192	24,192		24,192	2,216	26,408			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			48,288	48,288		48,288	16	48,304			26
27	Other (specify):*											27
28	TOTAL General Administration	38,233	8,659	353,116	400,008		400,008	144,854	544,862			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	801,387	120,762	536,166	1,458,315		1,458,315	142,821	1,601,136			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			58,886	58,886		58,886	295	59,181			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							3	3			32
33	Real Estate Taxes			36,475	36,475		36,475	21	36,496			33
34	Rent-Facility & Grounds							1,164	1,164			34
35	Rent-Equipment & Vehicles			7,085	7,085		7,085	118	7,203			35
36	Other (specify):* See Attached			324	324		324		324			36
37	TOTAL Ownership			102,770	102,770		102,770	1,601	104,371			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,106		1,106		1,106		1,106			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			34,588	34,588		34,588		34,588			42
43	Other (specify):* Lab & Rad											43
44	TOTAL Special Cost Centers		1,106	34,588	35,694		35,694		35,694			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	801,387	121,868	673,524	1,596,779		1,596,779	144,422	1,741,201			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(502)	02		4
5	Telephone, TV & Radio in Resident Rooms	(2,243)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(108)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(90)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,720)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>Vending Revenue</u>	(155)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (4,818)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	149,240	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 149,240		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 144,422		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	<u>Gift and Coffee Shops</u>		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Report Period Beginning:

Ending:

ID# 0043547

1/1/2004

12/31/2004

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Other-Attach Schedule - Goodwill	\$ 0		1
2	Other-Attach Schedule - Other non allowable exp	0		2
3	Other-Attach Schedule - Vending revenue	(155)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(155)		49

Summary A

12/31/2004

[illegible]

Summary B

12/31/2004

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Organizational Structure						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Senior Living Properties, LLC	100.00%	\$ 0	\$	1
2	V	2	Food Purchase		Senior Living Properties, LLC	100.00%	0		2
3	V	3	Housekeeping		Senior Living Properties, LLC	100.00%	0		3
4	V	4	Laundry		Senior Living Properties, LLC	100.00%	(155)	(155)	4
5	V	5	Heat and Other Utilities		Senior Living Properties, LLC	100.00%	0		5
6	V	6	Maintenance		Senior Living Properties, LLC	100.00%	972	972	6
7	V	7	Waste Removal		Senior Living Properties, LLC	100.00%	0		7
8	V	10	Nursing & Medical Records		Senior Living Properties, LLC	100.00%	3	3	8
9	V	10a	Therapy		Senior Living Properties, LLC	100.00%	0		9
10	V	17	Administrative		Senior Living Properties, LLC	100.00%	0		10
11	V	19	Professional Services		Senior Living Properties, LLC	100.00%	11,290	11,290	11
12	V	20	Dues, Fees, Subscriptions & Promotions		Senior Living Properties, LLC	100.00%	114	114	12
13	V	21	Clerical & General Office Expenses		Senior Living Properties, LLC	100.00%	133,183	133,183	13
14	Total			\$			\$ 145,407	\$ * 145,407	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Employee Benefits & Payroll Taxes	\$	Senior Living Properties	100.00%	\$ 0	\$	15
16	V	24	Travel and Seminar		Senior Living Properties	100.00%	2,216	2,216	16
17	V	26	Insurance - Prop Liab Malpractice		Senior Living Properties	100.00%	16	16	17
18	V	30	Depreciation		Senior Living Properties	100.00%	295	295	18
19	V	32	Interest		Senior Living Properties	100.00%	3	3	19
20	V	33	Real Estate Taxes		Senior Living Properties	100.00%	21	21	20
21	V	34	Rent - Facility & Grounds		Senior Living Properties	100.00%	1,164	1,164	21
22	V	35	Rent - Equipment & Vehicles		Senior Living Properties	100.00%	118	118	22
23	V	36	Loss, Goodwill, & Depreciation		Senior Living Properties	100.00%	0		23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 3,833	\$ * 3,833	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Senior Living Properties, LLC

Street Address

12900 N. Meridian Street, Suite 180

City / State / Zip Code

Carmel, Indiana 46032

Phone Number

(317)566-1586

Fax Number

(317) 581-9513

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	Dietary	See Attachment	See Attachment	See Attachment	\$ 0	\$	See Attachment	\$ 0	1
2	2	Food Purchase	See Attachment	See Attachment	See Attachment	0		See Attachment	0	2
3	3	Housekeeping	See Attachment	See Attachment	See Attachment	0		See Attachment	0	3
4	4	Laundry	See Attachment	See Attachment	See Attachment	(14,096)		See Attachment	(155)	4
5	5	Heat and Other Utilities	See Attachment	See Attachment	See Attachment	0		See Attachment	0	5
6	6	Maintenance	See Attachment	See Attachment	See Attachment	95,381		See Attachment	972	6
7	7	Waste Removal	See Attachment	See Attachment	See Attachment	0		See Attachment	0	7
8	10	Nursing & Medical Records	See Attachment	See Attachment	See Attachment	267		See Attachment	3	8
9	10a	Therapy	See Attachment	See Attachment	See Attachment	0		See Attachment	0	9
10	17	Administrative	See Attachment	See Attachment	See Attachment	0		See Attachment	0	10
11	19	Professional Services	See Attachment	See Attachment	See Attachment	1,026,001		See Attachment	11,290	11
12	20	Dues, Fees, Subscriptions & Prom	See Attachment	See Attachment	See Attachment	10,855		See Attachment	114	12
13	21	Clerical & General Office Expens	See Attachment	See Attachment	See Attachment	12,021,375		See Attachment	133,183	13
14	22	Employee Benefits & Payroll Tax	See Attachment	See Attachment	See Attachment	0		See Attachment	0	14
15	24	Travel and Seminar	See Attachment	See Attachment	See Attachment	272,954		See Attachment	2,216	15
16	26	Insurance - Prop Liab Malpractic	See Attachment	See Attachment	See Attachment	1,435		See Attachment	16	16
17	30	Depreciation	See Attachment	See Attachment	See Attachment	26,841		See Attachment	295	17
18	32	Interest	See Attachment	See Attachment	See Attachment	249		See Attachment	3	18
19	33	Real Estate Taxes	See Attachment	See Attachment	See Attachment	1,914		See Attachment	21	19
20	34	Rent-Facility & Grounds	See Attachment	See Attachment	See Attachment	105,820		See Attachment	1,164	20
21	35	Rent-Equipment & Vehicles	See Attachment	See Attachment	See Attachment	10,725		See Attachment	118	21
22	36	Loss, Goodwill, & Depreciation	See Attachment	See Attachment	See Attachment	0		See Attachment	0	22
23										23
24										24
25	TOTALS					\$ 13,559,723	\$		\$ 149,240	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

	<i>Important</i>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2003 report.	\$	30,653	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	30,653	2
3. Under or (over) accrual (line 2 minus line 1).	\$		3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	36,475	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	36,475	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1999	28,135	8
	2000	19,310	9
	2001	31,878	10
	2002	34,059	11
	2003	35,586	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003 \$		13
14	PLUS APPEAL COST FROM LINE 5 \$		14
15	LESS REFUND FROM LINE 6 \$		15
16	AMOUNT TO USE FOR RATE CALCULATION \$		16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

Firwood Health Care Center

COUNTY

Kane

FACILITY IDPH LICENSE NUMBER

0043547

CONTACT PERSON REGARDING THIS REPORT

William H. Keys

TELEPHONE

(317)566-1586

FAX #:

(317)581-9513

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 12-14-103-006	See Attached	\$ 35,585.80	\$ 35,585.80
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 35,585.80	\$ 35,585.80

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 14,290

B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories 1

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred: _____

2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____

4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.					
	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	79,279	1998	\$ 58,230	1
2					2
3	TOTALS	79,279		\$ 58,230	3

Facility Name & ID Number Firwood Health Care Center

0043547

Report Period Beginning:

1/1/2004

Ending:

12/31/2004

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	63		1998	1972	\$ 860,205	\$ 28,674	30	\$ 28,674	\$	\$ 198,325	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	repair furnace		1998		1,600	107	15	107		658	9
10	furnace installation		1998		8,500	567	15	567		3,872	10
11	6 burner oven convection		1998		4,113	411	10	411		2,536	11
12	garbage disposer		1998		1,467		5			1,467	12
13	Fluorescent Lights		1998		4,010	201	20	201		1,237	13
14	remodel shower room		1999		18,692	935	20	935		5,452	14
15	wood floor		1999		3,425	171	20	171		985	15
16	concrete footings		1999		6,845	342	20	342		1,854	16
17	support beams		1999		3,890	195	20	195		1,054	17
18	Metal Door Assembly		1999		950	48	20	48		257	18
19	Steam Table		1999		888	89	10	89		510	19
20	Gas Range		1999		4,263	426	10	426		2,451	20
21	Electric Panel		1999		2,988	166	18	166		858	21
22	water heater		1999		1,052	105	10	105		570	22
23	Wanderguard - Front Door		1999		1,385	138	10	138		750	23
24	Fire Sprinklers		1999		1,146	46	25	46		237	24
25	Sump Pit/Floor Supports		1999		6,065	303	20	303		1,643	25
26	building improvement		2000		1,302	87	15	87		376	26
27	Boiler		2000		650	93	7	93		371	27
28	open board fence		2002		1,400	175	8	175		350	28
29	roof repair		2003		1,500	150	10	150		200	29
30	roof work		2003		9,590	959	10	959		1,279	30
31	Water Heater		2001		975	65	15	65		249	31
32	3.5 Ton condensing unit		2003		1,175	235	5	235		353	32
33	Land Improvement		1998		24,298	1,620	15	1,620		11,204	33
34	Asphalt in parking lot, cart path		1998		11,760	1,470	8	1,470		9,310	34
35	Drainage system - Leechfield		1998		13,000	867	15	867		5,417	35
36	Signage		1998		464	46	10	46		305	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Man hole with bar grade screen	1999	\$ 4,472	\$ 179	25	\$ 179	\$	\$ 969	37
38	Seed and fertilizer	1999	1,945	195	10	195		1,054	38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,004,015	\$ 39,065		\$ 39,065	\$	\$ 256,153	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$148,391	\$19,198	\$19,198	\$	Various	\$130,500	71
72	Current Year Purchases	22,948	623	623		Various	623	72
73	Fully Depreciated Assets					Various		73
74								74
75	TOTALS	\$171,338	\$19,821	\$19,821	\$		\$131,123	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76				\$	\$	\$	\$		\$
77									
78									
79									
80	TOTALS			\$	\$	\$	\$		\$

E. Summary of Care-Related Assets					1	2
		Reference				Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)				\$1,233,583
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)				\$58,886
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)				\$58,886
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)				\$
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)				\$387,276

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☒ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☒ NO
- Terms: N/A
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$ 7,085
- Description: Nursing - 38, Central Supply - 113, Dietary - 607, Plant - 2,128, Laundry - 127, Administrative - 4,072
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	\$
13.	/2006	\$
14.	/2007	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

B. EXPENSES		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a,3	hrs	\$	0	\$ 0	\$ 0		\$	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		0	0	0			2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		0	0	0			4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (2,662,415)	1
2	Restatements (describe):		2
3	Accounting Adjustments	181,933	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (2,480,482)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(246,755)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (246,755)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,727,237)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,206,097	1
2	Discounts and Allowances for all Levels	(863,518)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,342,579	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	537	13
14	Non-Patient Meals	502	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	6,252	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 7,291	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Vending</u>	154	28
28a	<u>Vending</u>		28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 154	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,350,024	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	348,376	31
32	Health Care	709,931	32
33	General Administration	400,008	33
	B. Capital Expense		
34	Ownership	102,770	34
	C. Ancillary Expense		
35	Special Cost Centers	1,106	35
36	Provider Participation Fee	34,588	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,596,779	40
41	Income before Income Taxes (line 30 minus line 40)**	(246,755)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (246,755)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	0	0	\$ 0	\$	1
2	Assistant Director of Nursing	15	15	490	32.67	2
3	Registered Nurses	9,863	10,837	253,006	23.35	3
4	Licensed Practical Nurses	38	38	582	15.32	4
5	Nurse Aides & Orderlies	20,216	21,989	271,846	12.36	5
6	Nurse Aide Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0	0		8
9	Activity Director	1,740	2,037	25,611	12.57	9
10	Activity Assistants	0	0	0		10
11	Social Service Workers	1,322	1,444	17,551	12.15	11
12	Dietician	1,921	2,068	32,941	15.93	12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	5,655	6,448	76,647	11.89	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	1,054	1,193	15,518	13.01	17
18	Housekeepers	5,323	5,862	57,466	9.80	18
19	Laundry	980	1,103	11,015	9.99	19
20	Administrator	97	97	5,088	52.45	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	1,868	2,102	33,145	15.77	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	39	39	481	12.33	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	50,131	55,272	\$ 801,387 *	\$ 14.50	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	98	\$ 3,600	1, 3	35
36	Medical Director	96	7,200	9, 3	36
37	Medical Records Consultant			10, 3	37
38	Nurse Consultant			10, 3	38
39	Pharmacist Consultant	44	1,100	10, 3	39
40	Physical Therapy Consultant			10a, 3	40
41	Occupational Therapy Consultant			10a, 3	41
42	Respiratory Therapy Consultant			10a, 3	42
43	Speech Therapy Consultant			10a, 3	43
44	Activity Consultant	48	3,062	11, 3	44
45	Social Service Consultant	48	3,503	12, 3	45
46	Other(specify) <u>Administrative Consu</u>	2,080	82,281	17,3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,414	\$ 100,746		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,080	\$ 72,212	10,3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,080	\$ 72,212		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
			\$	Workers' Compensation Insurance	\$	53,673	IDPH License Fee	\$
				Unemployment Compensation Insurance		0	Advertising: Employee Recruitment	4,764
				FICA Taxes		90,844	Health Care Worker Background Check	670
				Employee Health Insurance		(8)	(Indicate # of checks performed <u>56</u>)	
				Employee Meals				
				Illinois Municipal Retirement Fund (IMRF)*		2,012	Dues & Subscriptions	10,839
							Advertising & Public Relations	1,720
TOTAL (agree to Schedule V, line 17, col. 1)			\$				Home Office Allocation	114
(List each licensed administrator separately.)							Less: Public Relations Expense	(
B. Administrative - Other							Non-allowable advertising	(1,606)
Description			Amount				Yellow page advertising	(
Contract Services: Administrator			\$ 82,281					
Misc. Fees			0					
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 82,281					
(Attach a copy of any management service agreement)								
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Legal Fees	Various		\$ 90			\$	Out-of-State Travel	\$
Patient Litigation	Various		0					
Payroll Processing	Various		2,462					
Accounting	Various		3,533				In-State Travel	23,148
EDP Services	Various		13,929					
							Seminar Expense	293
							Business Meals	751
							Home Office Allocation	2,216
							Entertainment Expense	(
TOTAL (agree to Schedule V, line 19, column 3)			\$				(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)			20,014	TOTAL		\$	TOTAL	\$ 26,408

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1)

Are nursing employees (RN,LPN,NA) represented by a union?

No
- (2)

Are there any dues to nursing home associations included on the cost report?

No

If YES, give association name and amount.

0 N/A
- (3)

Did the nursing home make political contributions or payments to a political action organization?

No

If YES, have these costs been properly adjusted out of the cost report?

N/A
- (4)

Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

No

If YES, what is the capacity?

N/A
- (5)

Have you properly capitalized all major repairs and equipment purchases?

Yes

What was the average life used for new equipment added during this period?

5 years
- (6)

Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$ 10,570

Line 10
- (7)

Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

Yes

If NO, attach a complete explanation.
- (8)

Are you presently operating under a sale and leaseback arrangement?

No

If YES, give effective date of lease.

N/A
- (9)

Are you presently operating under a sublease agreement?

YES

X

NO
- (10)

Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A
- (11)

Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.

\$ 34,588

This amount is to be recorded on line 42 of Schedule V.
- (12)

Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

No

If YES, attach an explanation of the allocation.

- (13)

Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

Yes
- (14)

Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

No

For example, is a portion of the building used for rental, a pharmacy, day care, etc.)

If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15)

Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$ N/A

Has any meal income been offset against related costs?

Yes

Indicate the amount.

\$ 502
- (16)

Travel and Transportation

a. Are there costs included for out-of-state travel?

No

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

No

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$ N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

N/A

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

No

Indicate the amount of income earned from providing such transportation during this reporting period.

\$ N/A
- (17)

Has an audit been performed by an independent certified public accounting firm?

No

Firm Name:

N/A

The instructions for the cost report require that a copy of this audit be included with the cost report.

Has this copy been attached?

N/A

If no, please explain.

N/A
- (18)

Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

Yes
- (19)

If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?

N/A

Attach invoices and a summary of services for all architect and appraisal fees.